SERFF Tracking Number:	*BNLA-125811645*	*State:*	*Arkansas*
Filing Company:	*Bankers Life and Casualty Company*	*State Tracking Number:*	*40314*
Company Tracking Number:	*17300A*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Limited Benefit Application*		
Project Name/Number:	*17300A-AR/17300a*		

Filing at a Glance

Company: Bankers Life and Casualty Company

Product Name: Limited Benefit Application	SERFF Tr Num: BNLA-125811645	State: ArkansasLH
TOI: H13I Individual Health - Short Term Care	SERFF Status: Closed	State Tr Num: 40314
Sub-TOI: H13I.002 Nursing Home	Co Tr Num: 17300A	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Thomas Kimble, Dan Murphy	Disposition Date: 09/23/2008
	Date Submitted: 09/22/2008	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 17300A-AR

Project Number: 17300a

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/23/2008

State Status Changed: 09/23/2008

Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

Filing Description:

RE: Individual Health Insurance

Convalescent Care Insurance

Application Form 17300A

Dear Commissioner:

SERFF Tracking Number:	*BNLA-125811645*	*State:*	*Arkansas*
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Company Tracking Number:	*17300A*		
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Product Name:	*Limited Benefit Application*		
Project Name/Number:	*17300A-AR/17300a*		

We are filing the above referenced application form for your consideration and approval. This filing contains no unusual or controversial items from normal Company or industry standards. This form is new and not intended to replace any existing policy forms. This application will be used with our Convalescent Care Policies, forms GR-N560 and GR-N565, which were approved by your Department on 10-18-07.

Application 17300A is designed to be used by our agents in your state to solicit our approved Convalescent Care Policies. This form has been designed to meet Optical Character Recognition (OCR) and Intelligent Character Recognition (ICR). This form will be used in both paper and electronic formats. When used in an electronic format, the spacing and font may vary from the paper format, but the text and order of the application will not change.

We request that you allow us to file Sections 1.C., Policy Options and 10, Applicant's Acknowledgment of Notice, as variable so we can use this application with any future policy forms or notices that may be developed or required. These two sections would be the only variable information in the application.

The Flesch Test Readability score for this form is 51.85.

This form has been filed in Company's home state of Illinois and is currently pending.

We respectfully request your favorable consideration and approval of this filing. If you have any questions or need additional information, please feel free to contact me.

Company and Contact

Filing Contact Information

Dan Murphy, Compliance Administrator
222 Merchandise Mart Plaza
Chicago, IL 60654-9988

d.murphy@banklife.com
(312) 396-6134 [Phone]
(312) 396-5907[FAX]

Filing Company Information

Bankers Life and Casualty Company
600 West Chicago Ave
Chicago, IL 60654-2800
(800) 621-3724 ext. [Phone]

CoCode: 61263
Group Code: 233
Group Name:
FEIN Number: 36-0770740

State of Domicile: Illinois
Company Type:
State ID Number:

SERFF Tracking Number:	*BNLA-125811645*	*State:*	*Arkansas*
Filing Company:	*Bankers Life and Casualty Company*	*State Tracking Number:*	*40314*
Company Tracking Number:	*17300A*		
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Project Name/Number:	*17300A-AR/17300a*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	1 form filing @ $50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Bankers Life and Casualty Company	$50.00	09/22/2008	22639459

SERFF Tracking Number:	*BNLA-125811645*	*State:*	*Arkansas*
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Product Name:	*Limited Benefit Application*		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/23/2008	09/23/2008

SERFF Tracking Number:	*BNLA-125811645*	*State:*	*Arkansas*
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Product Name:	*Limited Benefit Application*		
Project Name/Number:	*17300A-AR/17300a*		

Disposition

Disposition Date: 09/23/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*BNLA-125811645*	*State:*	*Arkansas*
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Project Name/Number:	*17300A-AR/17300a*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

SERFF Tracking Number:	*BNLA-125811645*	*State:*	*Arkansas*
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Project Name/Number:	*17300A-AR/17300a*		

Form Schedule

Lead Form Number: 17300A

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	17300A-AR	Application/ Enrollment Form	Application	Initial		52	17300A-AR.pdf

APPLICATION FOR INSURANCE TO

BANKERS LIFE AND CASUALTY COMPANY("The Company")
600 West Chicago Ave, Chicago, IL 60654-2800

1. Policy Information (PLEASE CLEARLY PRINT ALL INFORMATION)

A. I apply for ❍ **NEW COVERAGE** ❍ **EXCHANGE** ❍ **ADDED MEMBER** ❍ **REINSTATEMENT** ❍ **POLICY CHANGE**

B. Policy No.(s) of Bankers' Policy(ies) to be changed

C. **FORM NUMBER APPLIED FOR** ❍ **GR-N560** ❍ **GR-N565** ❍ **OTHER**

POLICY OPTIONS

Maximum Benefit Multiplier/Elimination Period	❍ 90 Days / 0 Days	❍ 90 Days / 15 Days ❍ 180 Days / 15 Days ❍ 270 Days / 15 Days ❍ 360 Days / 15 Days	❍ 90 Days / 30 Days ❍ 180 Days / 30 Days ❍ 270 Days / 30 Days ❍ 360 Days / 30 Days

Nursing Home Care

Maximum Daily Benefit Amount $. 0 0

D. Compound Increases Option ❍ Yes ❍ No

E. Special Issue Date (mm-dd-yy) - - 20

2. Personal Information of Person(s) to be Insured

A. Applicant's First Name M.I. Last Name Suffix

Gender: ❍ M ❍ F Marital Status: ❍ Married ❍ Single ❍ Widowed ❍ Divorced

Date of birth (mm-dd-yyyy) Age Height (Feet and Inches) Weight (Pounds)

B. Spouse's First Name M.I. Last Name Suffix

Gender: ❍ M ❍ F Marital Status: ❍ Married ❍ Single ❍ Widowed ❍ Divorced

Date of birth (mm-dd-yyyy) Age Height (Feet and Inches) Weight (Pounds)

3. Contact Information

A. Home Address

City/Town State Zip Code

Home Phone Work Phone

E-mail Address

B. Billing Address (if different than home address)

City/Town State Zip Code

BLCI17300AAR01

4. Association/Organization Verification (complete this section only if applicable)

The Applicant is an employee/member in good standing of:

Association/Organization _____ Account Number _____

5. Qualifying Information

If any person to be insured answers "Yes" to any part of the questions in this section he or she is not eligible for this coverage.

	Applicant		Spouse	
	YES	**NO**	**YES**	**NO**
a. Are you now confined or in the last 90 days been confined in a Hospital?	❍	❍	❍	❍
b. In the last year, have you, due to mental or physical disability, authorized any person or institution to legally act on your behalf, and take over your personal business transactions?	❍	❍	❍	❍
c. Do you need or in the last three years have you needed the help of another person to eat, bathe, dress, get in or out of bed or a chair, use the toilet, or maintain personal hygiene due to incontinence?	❍	❍	❍	❍
d. Do you use or in the last three years have you used a wheelchair, walker, catheter, oxygen or a dialysis machine?	❍	❍	❍	❍
e. Within the past three years, have you:				
(1) Received or been advised by a health care professional to receive Home Health Care or Adult Day Care Services or been confined in or advised to enter a Nursing Home, Assisted Living or other type of Long Term Care Facility?	❍	❍	❍	❍
(2) Been diagnosed with or treated for Parkinson's Disease, memory loss, dementia, Alzheimer's Disease, stroke or transient ischemic attack (TIA)?	❍	❍	❍	❍
(3) Been diagnosed with or treated for cancer (except basal cell or squamous cell cancer of the skin)?	❍	❍	❍	❍
(4) Been diagnosed with or treated for alcohol abuse, prescription drug abuse or illegal drug use?	❍	❍	❍	❍
f. Do you receive or in the last three years have you received federal, state, or local government assistance in any form, such as Supplemental Security Income; Social Security Disability Income; having Medicare premiums paid for by the state; eligible for Medicare due to a disability; or Medicaid?	❍	❍	❍	❍
g. Are you receiving or in the last three years have you received active treatment for a problem causing total disability?	❍	❍	❍	❍
h. Have you ever had any of the following complications due to diabetes: leg or foot ulcers; total vision loss; amputation(s); total loss of feeling in your leg or foot; kidney disease?	❍	❍	❍	❍
i. Has a health care professional recommended any surgery that has not yet been performed?	❍	❍	❍	❍

6. Replacement of Existing Coverage

Will any existing ❑ Life, ❑ Health, ❑ Accident & Sickness, ❑ Disability Income or ❑ Annuity Contract(s) be replaced or changed if a proposed policy or certificate is issued? If "Yes," give details below:	**YES**	**NO**
	❍	❍

(1) Applicant

Company	Policy Number	End Date (mm-dd-yy)
		- - 20
		- - 20

6. Replacement of Existing Coverage (Continued)

(2) Spouse

_____ _____ __ - __ - 20 __

_____ _____ __ - __ - 20 __

7. Premium Payment Service Plan Information (if applicable)

I want my policy to be paid on bank draft.

_____

Bank Routing/Transit Identification Numbers (first set of numbers in the lower left hand bottom of check - 9 digits)

_____ _____

❍ Checking or ❍ Savings Account Number — Account Name

_____

Bank Name

_____ __ _____ - ____

City/Town — State — Zip Code

Please charge my account by draft or Electronic Fund Transfer notice on the __ day of the month.

I also want these policy/certificate numbers on bank draft:

_____ _____ _____

8. Authorization

In connection with an application for insurance currently made to Bankers Life and Casualty Company. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or any of the members of my family named in said application or of our health, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. This authorization will be valid for a period of 2 years and 6 months from the date signed. I understand and agree that this policy may include an administrative remedies provision which must be exhausted prior to any other action being taken at law or in equity. The provision provides for arbitration, which may be binding, depending on applicable state or federal law.

9. Acknowledgments

THE APPLICANT REPRESENTS AND AGREES AS FOLLOWS:

a. I have read, or had read to me, the completed application and realize that any false statements or misrepresentation in this application may result in loss of coverage under the policy.

b. No agent or any other person is authorized to accept risks, pass upon insurability, make or modify contracts or waive any of the Company's rights or requirements.

c. Any insurance issued as a result of the application will either: a. Not take effect unless and until the full first premium is paid and the policy is delivered during such person's lifetime and while such person is in the condition of health set forth in the application; or: b. Take effect only as specified in the Receipt, if any, attached to this application.

d. For any exchange, the new coverage will be treated as a renewal of any current coverage.

e. For policy changes, all waiting periods in the coverage will apply to any increase in benefits. The waiting periods will start on the effective date of the increase.

f. I understand that the Company may offer both federally tax-qualified and non-qualified Long Term Care contracts having similar benefits. The contract I have applied for on this application is neither a Long Term Care Policy nor a federally tax-qualified contract. I understand that this policy does not provide federal income tax advantages.

10. Applicant's Acknowledgment of Notices

The applicant has received and acknowledges receipt of the following forms:

- Outline of Coverage
- Notice to Applicants for Insurance (regarding the Applicant's rights under the Fair Credit Reporting Act)
- Notice About Insurance Information Practices and the Privacy Protection Act (if applicable)
- Privacy Notice
- "The Guide to Health Insurance for People with Medicare" (if eligible for Medicare)
- Conditional Receipt (if applicable)
- Notice Regarding Replacement Form (if applicable)

11. Remarks: _____

13. Signatures

I certify that the statements contained in the application concerning past and present health are complete, true and correct.

Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind your coverage.

Dated at City/Town _____ State _____ Zip Code _____ - _____

This _____ Day of _____ 20 _____

Signature of Applicant X _____

Signature of Spouse X _____

Social Security Number(s)

Applicant _____ Spouse (if to be insured) _____

I have witnessed the signature of the Applicant and Spouse, if also applying. I certify that I asked all the applicable questions and truly and accurately recorded the answers contained herein. I certify that the Applicant has read the completed application or had it read to him or her. To the best of my knowledge and belief, except as may be stated by the Applicant's response to Question 6, the insurance applied for is not or is not likely to replace or change any existing policy(ies) or contract(s).

Signature of Licensed Resident Agent X _____ Agent No. _____ _____ %

Branch Office Number _____

Signature of Licensed Resident Agent X _____ Agent No. _____ _____ %

Branch Office Number _____

MAKE ALL CHECKS PAYABLE ONLY TO BANKERS LIFE AND CASUALTY COMPANY

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SERFF Tracking Number:	*BNLA-125811645*	*State:*	*Arkansas*
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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Satisfied -Name: Certification/Notice
Review Status: Approved-Closed 09/23/2008
Comments:
Attachments:
READABILITY CERTIFICATION 17300A.pdf
Certif of Compliance with Rule 19.pdf

Bypassed -Name: Application
Review Status: Approved-Closed 09/23/2008
Bypass Reason: Please see form schedule.
Comments:

Bypassed -Name: Health - Actuarial Justification
Review Status: Approved-Closed 09/23/2008
Bypass Reason: Not Applicable - Application Filing Only
Comments:

Bypassed -Name: Outline of Coverage
Review Status: Approved-Closed 09/23/2008
Bypass Reason: Not Applicable - Application Filing Only
Comments:

READABILITY CERTIFICATION

Company Name: Bankers Life and Casualty Company

NAIC Number: 233-61263

As an officer of Bankers Life and Casualty Company, I hereby certify that the below captioned forms achieve the following readability scores as calculated by the Flesch Reading Ease Test and that these forms meet the reading ease requirements in your state.

Flesch Score	Form Number	Description
51.8	17300A	Convalescent Care Insurance Policy – Application

Mariann Dobbs

_____ **09/22/08**

Mariann Dobbs **DATE**
Assistant Secretary

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: **Bankers Life and Casualty Company**

Form Number(s): 17300A-AR

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Signature of Company Officer

Mariann Dobbs
Name

Assistant Secretary
Title

09/22/2008
Date